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ABSTRACT

Presented in this final volume are the Graduate Medical Education National Advisory Committee (GMENAC) members' commentaries and appendix. Included are: the members and staff of GMENAC; a preface; individual member's commentaries; appendices that include GMENAC recommendations from each of the other six volumes; a cross reference of GMENAC recommendations; official GMENAC votes on final report volumes; and GMENAC's charter. Recommendations are given from the other six volumes: Summary Report (Volume I); Modeling, Research and Data Technical Panel (Volume II); Geographic Distribution Technical Panel (Volume III); Financing Technical Panel (Volume IV); Educational Environment Technical Panel (Volume V); and Nonphysician Health Care Provider Technical Panel (Volume VI). The recommendations are aimed at achieving five manpower goals: (1) to achieve a balance between supply and requirements of physicians in the 1990s, while assuring representation of minority groups; (2) to integrate manpower planning of physicians and nonphysician providers when their services are needed; (3) to achieve a better geographic distribution of physicians and to improve health service in small areas; (4) to improve specialty and geographic distribution of physicians through financing mechanisms for medical education, graduate education, and practice; and (5) to support research for the next phases of health manpower planning. (LC)

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Report of the Graduate Medical Education National Advisory Committee to the Secretary, Department of Health and Human Services

ED203771

Volume VII

GMENAC Members' Commentaries and Appendix

HE 014 028

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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The Report of the Graduate Medical Education National Advisory Committee to the Secretary, Department of Health and Human Services, consists of seven volumes:

Volume I GMENAC Summary Report

Volume II Modeling, Research, and Data Technical Panel

Volume III Geographic Distribution Technical Panel

Volume IV Financing Technical Panel

Volume V Educational Environment Technical Panel

Volume VI Nonphysician Health Care Providers Technical Panel

Volume VII GMENAC Members' Commentaries and Appendix

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Report of the
Graduate Medical Education National Advisory Committee

to the Secretary, Department of Health and Human Services

Volume VII

GMENAC Members' Commentaries and Appendix

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U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Public Health Service
Health Resources Administration
Office of Graduate Medical Education
DHHS Publication No. (HRA) 81-657

September 30, 1980

The Honorable Patricia Roberts Harris
Secretary
Department of Health and Human Services
Washington, D.C. 20201

Dear Madam Secretary:

The attached Report of the Graduate Medical Education National Advisory Committee (GMENAC) is in fulfillment of the Committee's responsibilities under the Charters of April 20, 1976, and March 6, 1980.

The charge of the Committee was to advise the Secretary on the number of physicians required in each specialty to bring supply and requirements into balance, methods to improve the geographic distribution of physicians, and mechanisms to finance graduate medical education.

GMENAC significantly advanced health manpower planning in direct and indirect ways.

GMENAC introduced new scientific methodology: Two new mathematical models were developed to estimate physician supply and requirements.

GMENAC refined the data bases; figures for estimating the supply of practitioners in every specialty and subspecialty from the distribution of first-year residency positions have been developed.

GMENAC integrated the estimates of supply and requirements for physicians with nurse practitioners, physician assistants, and nurse midwives.

GMENAC introduced new concepts to clarify assessment of the geographic distribution of physicians and services; standards are proposed for designating areas as adequately served or underserved based on the unique habits of the people in the area.

GMENAC recommends that medical service revenues continue to provide the major source of funds to support graduate medical education.

GMENAC has initiated a collaboration between the private sector and the Government; the unique expertise of each achieves a level of comprehensiveness in health manpower planning not previously experienced.

GMENAC estimates a surplus of 70,000 physicians by 1990. Most specialties will have surpluses, but a few will have shortages. A balance by 1990 cannot be achieved. Until supply and requirements reach a balance in the 1990s, GMENAC recommends that the surplus be partially absorbed by expansion of residency training positions in general/family practice, general pediatrics, and general internal medicine.

Recommendations are directed at achieving five manpower goals:

1. To achieve a balance between supply and requirements of physicians in 90s, while assuring that programs to increase the representation of minority groups in medicine are advanced by programs to broaden the applicant pool with respect to socio-economic status, age, sex, and race;

2. to integrate manpower planning of physicians and nonphysician providers when their services are needed, and to facilitate the function of nonphysician providers;

3. to achieve a better geographic distribution of physicians and to establish improved mechanisms for assessing the adequacy of health services in small areas;

4. to improve specialty and geographic distribution of physicians through financing mechanisms for medical education, graduate medical education, and practice, and

5. to support research for the next phases of health manpower planning.

The Committee unanimously recommends the immediate establishment of a successor to GMENAC. Its establishment is essential to the implementation of the manpower goals and recommendations in the Report. The full GMENAC methodology must be applied to the six specialties which have not been analyzed. The requirements estimates for each of the specialties and subspecialties must be tested, monitored, and reassessed on a continuing basis. Important studies on financing, geography, and nonphysician providers should be undertaken.

The collaborative working relationship between the private sector and the Government facilitated a congruence of interest in planning and in implementing improvements to best meet the needs of the Nation. The momentum of this collaboration should be continued without interruption.

Respectfully submitted,

Alvin R. Tarlov

Alvin R. Tarlov, M.D.
Chairman
Graduate Medical Education
National Advisory Committee

For the Committee

Enclosure: Volumes I-VII

MEMBERS AND STAFF — GRADUATE MEDICAL EDUCATION

NATIONAL ADVISORY COMMITTEE

(GMENAC)

The following pages provide a complete roster of GMENAC Committee members, both present and former. It should be noted that only present members voted on volumes contained in the Committee's Final Report. Principal staff persons to this effort are also identified.

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PREFACE

This volume, GMENAC's Members' Commentaries and Appendix, represents an integral part of the Final Report of the Graduate Medical Education National Advisory Committee (GMENAC).

The Committee officially voted on and approved each of the other six volumes of the Final Report. Volume I consists of the Summary Report and Volumes II-VI consist of reports developed by GMENAC Technical Panels. As part of the Committee process for considering these volumes, all GMENAC members were provided an opportunity to prepare individual member commentaries and have them included (unedited) in the Final Report.

The Charter and membership composition of GMENAC are provided. In addition, Volume VII contains as an Appendix the official GMENAC votes on each section of the Final Report, a cross-reference of GMENAC recommendations, and all recommendations of the Committee contained in Volumes I-VI.

INDIVIDUAL MEMBER COMMENTARIES

The commentaries of individual Committee members which follow are those that were received in time for inclusion in the GMENAC Final Report presented on September 30, 1980 to the Secretary, Department of Health and Human Services. The possibility exists that some member commentaries were in transit at that time and, therefore, not available for inclusion here. Any such commentaries will be transmitted separately to the Secretary and will appear in the edition of the Final Report being printed for general distribution.

Commentaries that are presented here have been reproduced in the form received.

Individual Commentary
Carl J. Barrera
GMENAC Member

I have participated in the work of GMENAC since January 1980 and during that period I believe that I was the only Member of GMENAC whose primary occupation was working for a health care payor. As Assistant General Counsel of Metropolitan Life Insurance Company, I, from time to time, consulted with others in my company to obtain their advice. However, I wish to emphasize that my views expressed at GMENAC committee meetings, my votes on issues before GMENAC, and this statement are solely the product of my own judgment, and are not in any way intended to represent the views of Metropolitan Life Insurance Company, the private insurance industry or other health care payors.

In general, I endorse the entire report and commend the dogged determination and fertile intelligence that was brought to bear in pursuing answers to obviously difficult questions.

While GMENAC dealt primarily with graduate medical education, it seemed clear to all concerned that the real issues that had to be dealt with were much more global questions. They were: how many health care providers, of what type, should provide what kind of health care, to whom, in what quantity and quality, in which places, and at what cost? While we were cognizant of such monumental questions, we could only focus on such questions in limited ways. Nevertheless, I suggest that the following matters are important and deserve special attention and study.

1. Outcome Studies: Since millions of dollars of governmental and private funds are being spent annually on health care, it seems anomalous that so little seems to be spent on outcome studies which may indicate what amount and type of health care is necessary or adequate. In the absence of such studies, the nation could be spending millions of dollars for decades in health care efforts which are of doubtful value.

2. Physician Surplus: GMENAC implicitly assumed that a surplus of physicians was an ill to be avoided. I tend to agree with that assumption, but it is an assumption which deserves more study, from a medical, as well as an economic point of view. Governmental acts aimed at

limiting the supply of physicians run contrary to the freedom of the marketplace which otherwise acts to limit the supply of other occupations and professions. Of course, in the light of projected surpluses of physicians, it is reasonable to curtail governmental incentives to increase the number of physicians. However, it is a different policy question for the government to do more than that without further studies of the effects of physician surpluses.

3. Reimbursement Practices: GMENAC considered that reimbursement practices could be utilized as tools to carry out changes in health care policy. However, it must be realized that the insurance industry is generally not in the position to change fundamental reimbursement concepts, such as the usual-customary-reasonable basis for reimbursement. Such concepts evolve in many cases from negotiated labor/management agreements and are otherwise embedded in the marketplace. If changes are to be introduced in the reimbursement system, all payors, both public and private, should participate. GMENAC would have been well served to have had within its membership persons associated with public payors and persons involved with negotiating labor/management agreements.

4. Health Care Costs: I believe that we could achieve better health care for the nation without incurring substantially higher costs if more measures were taken to reduce health care costs. Such measures could include: (a) A medical school requirement that all students take a course on the economic impact of medical practice; (b) A hospital requirement that the approximate cost of procedures and tests be shown on documents used to order them; and (c) An effort by a study group (which includes physicians, attorneys, health facility administrators, insurance industry representatives and government officials) to develop "standards" of health care for certain conditions, which if performed would be presumed by courts of law to constitute an adequate defense against malpractice suits. If some success in this direction could be accomplished, it could save substantial health care costs, provide physicians with a limited "safe harbor," and might serve to inform the patient of the expected "standard" treatment in certain situations.

5. Ambulatory Care*: GMENAC recognizes that the present structure of fees charged by physicians and the present system of reimbursement tends to better remunerate those physicians with in-hospital patients than those with ambulatory patients, even though the time the physician has spent with the ambulatory patient may far exceed that spent with the in-hospital patient. One of the problems with changing that system is in developing a means of quantifying the values of the skill needed and the time spent in various treatments performed in an ambulatory setting in a manner subject to reasonable verification. A study of possible alternate approaches seems necessary if changes are to be made in such fees and reimbursement practices. A successful implementation of such changes may contribute to a better disbribution of medical care geographically and by medical specialty, to lower hospital use and in the end to lower total health care costs.

Overall I am impressed with the academic effort and results of GMENAC and if the political process can be equally well martialed, a thoughtful process can be consumated in better health care for all Americans.

*"Ambulatory Care" - As used here is intended to exclude surgery and such other procedures which are more often performed in hospital settings.

Carl J. Barrera
GMENAC - Member

September 26, 1980
Date

Department of Medicine and Surgery
Washington, D.C. 20420

Veterans Administration

SEP 23 1980

Alvin R. Tarlov, M.D.
Chairman, GMENAC
Department of Medicine
The Division of Biological Sciences &
The Pritzker School of Medicine
University of Chicago
950 East 59th Street
Chicago, IL 60637

Dear Dr. Tarlov:

The Department of Medicine and Surgery of the Veterans Administration is pleased to have had representation during the deliberations of GMENAC. The unique role of the Veterans Administration health care system demands clarification as a part of the final report.

1. The health care needs of the veteran population are based on a different model than the national model used by GMENAC. Therefore, there is no need for pediatricians and a very limited one for OB/GYN specialists, but a specific need in fields such as radiology, pathology, and anesthesiology. We are in concert with the greater need in physiatry, general psychiatry and already play a major role in expanding the field of nuclear medicine.

2. The aging, largely male, population that we serve will have specific needs not reflected in a national health-care needs profile. Specialists in gerontology, sensory restoration and rehabilitation must be recruited and trained to enable the Veterans Administration to meet its specific health care mission.

3. The Veterans Administration respects its responsibility to help meet the training needs of the nation for health care professionals but must also protect its obligation to the population of veterans it serves. We ask that the recommendations of GMENAC reflect the special needs of the VA patients so we might meet our responsibilities both national and VA-specific. My office and the Office of Academic Affairs stand ready to assist in the careful, long-range planning of graduate medical education within the VA to meet these obligations and needs.

Sincerely,

DONALD L. CUSTIS, M.D.
Chief Medical Director

6 20

In Reply Refer To: 14

Individual Commentary
Tom E. Nesbitt, M. D.
GMENAC Member

Honorable Patricia Harris
Secretary Department Health and Human Services
Washington, D. C. 20510

Dear Madam Secretary:

As an original member of GMENAC I appreciate this opportunity to present my comments, concerns and differing positions relative to the recommendations contained in the Summary Report. I would initially like to express to you my personal appreciation of this opportunity to participate in what I consider to be an outstanding example of a successful collaborative effort between the private sector and the public sector of our nation to address a major policy issue. It has been a privilege to work with the distinguished members of GMENAC. I would be remiss if I failed to also express my great appreciation to the outstanding members of the Staff from HRA who have been assigned to this project since its inception. I should like to address my initial remarks to a few general observations and then speak specifically to selected recommendations as they appear in the summary document.

GENERAL CONSIDERATIONS:

1. Despite many initial personal reservations as to the potential for the successful completion of the GMENAC charge, I now strongly support the concept of predictive capability and forecasting that has been possible through the use of the requirements model and the supply model. The GMENAC development of the requirements model is a significant breakthrough in methodology which can serve our nation extremely well for the future. The technology will require expansion and sophistication of the data base for more precise requirements projections in the future. The data bases available to GMENAC were not totally satisfactory for current projections, but on balance provided us with the methodology for the future. Both the requirements model and the supply model will require continuous monitoring and adjustments by a future GMENAC-like body to improve upon the dynamic process of manpower projection techniques.
2. It is imperative that a GMENAC-like body be created and charged with the responsibility outlined above.
3. The singularly most important consideration in the voluntary implementation of GMENAC's recommendations by both the private and public sector will need to be repeatedly emphasized and stressed. Virtually all recommendations become central to the first two. It, therefore, becomes imperative that all recommendations be synchronized to provide the gradual simultaneous intertwining of all recommendations to avoid major disruptions in the delivery of medical care services. Should such an approach fail to occur, it can be stated realistically that the resulting upheaval could properly be described as lying somewhere between disruptive and chaotic.

COMMENTS RELATIVE TO SPECIFIC RECOMMENDATIONS:

Rec. 1. It is clearly recognized that this will be difficult to achieve, but any steps taken to implement any of the recommendations of this report should relate and revolve around this singularly most important recommendation.

Rec. 4. It should be emphasized that the GMENAC projections of medical specialties in which there will be surpluses or shortages in 1990 should not be interpreted as absolutes. Worthwhile and progressive though the GMENAC effort has been, the imperfections and the data and the methodology used as well as the assumptions on which the projections are made, require that the findings be understood only as general indicators of trends. Consequently, any adjustments in the number of trainees in any residency program should be made very gradual, lest areas of foreseen shortage become areas of "oversupply" and vice versa.

Rec. 5. To again note the imperfections and data and methodology, consideration should also be given to addition of the phrase "and to a lesser degree, general surgery". The dynamic nature of the changing delivery system demands that allowances be made for unknown advances in surgical treatment of disease.

Rec. 6. The research called for by this recommendation will require a host of carefully constructed studies and perhaps more demonstration projects. It will add considerably to the work load of a GMENAC-like successor. To be meaningful and accurate, research and analysis of the 4th item of this recommendation, "--relative costs and expenditures of using nonphysicians in place of physicians for selected medical care services--" must take into account the findings of a subsequent item, "--the professional longevity of nonphysician providers--". The costs of producing need to be compared to productivity over time.

Rec. 9. Items (b) and (c) in this recommendation deal with the desirability of expanding the prescription and/or dispensation of drugs by nonphysician health care providers. It is imperative that extreme caution be taken in this regard since it is questionable whether such nonphysician providers have the necessary education and training to make an appropriate medical judgment regarding the drug of choice.

Rec. 14. To deal with functional medical service areas, by specialty, in order to assess the availability of physician services, runs the risk of ignoring the reality that the medical services delivered by most physicians are not confined to those of the specialty in which they are categorized. In seeking to define physician market areas by using such information as discharge and claims data, great care must be taken to maintain requisite confidentiality.

Rec. 16. (a) (b) PSRO's are already doing much of what is requested in these recommendations. They serve no significant purpose in this report and are easily susceptible to misinterpretation. To be meaningful, any such comparisons require common definitions and weighing to account for demographic differences. As it is written, the recommendation assumes a standard of comparison across populations and regions.

Rec. 17. In my view Recommendation 17 simply cannot be supported

in any way. The recommendation, itself, plus the two supportive recommendations (a) and (b) should be deleted from the report. They simply violate the GMENAC modeling process; they are inadequately researched; they do not recognize the way in which physicians actually function. Moreover, they open the door to the establishment of quite arbitrary quotas and national standards which have no applicability to the totality of the delivery system of medicine.

Rec. 28. In my view this should be strengthened to add parenthetically that general institutional support to centers of medical education should be continued if the full impact of the preceeding recommendations is to be accomplished.

Rec. 39. The work of GMENAC should be continued. It should be accomplished by an advisory body that is charted and funded by administrative other than statuatory authority, in my view. The establishment by statute would too readily lead to misinterpreting the recommendations of such a body as regulatory rather than advisory. The private sector is prepared and already conducting many studies in parallel and there are at least two additional agencies in government already involved in such activities. Better communication and collaberation between these sources would accomplish the objective--namely that the work of GMENAC be continued.

Beyond comments related to this summary of recommendations contained in the overview and summary document, I have a series of major disagreements with recommendations which were presented by the Geographic Panel which revolve around the Geographic Panel's recommendations 30 and 31. Their recommendation 13 states that "the role of economic factors in location choice is not clear". Therefore, it seems inconsistent to make recommendations to manipulate reimbursement mechanisms as a means of influencing specialty and geographic distribution of physicians. One of the factors on which an appropriate level of reimbursement should be based, is the skill and ability of the practitioner.

Tom E. Nesbitt, M. D.

GMENAC Member

September 27, 1980

Individual Commentary
Karen O'Rourke, RN, MS
GMENAC Member

It has been a valuable educational experience and personal honor to have contributed to the work of GMENAC in preparing the final report on graduate medical education. As the AFL-CIO Representative and as a health care provider, I welcome the challenge of continued work with GMENAC. Despite the time limitations placed upon me as a new appointee to a council well established in its research and evaluation methods, I can confidently say that the exposure to medical politics which I have received during the GMENAC proceedings is indeed an enlightening one. While the final report reflects the opinion primarily of physicians, who comprised more then a simple majority on GMENAC, I venture to add the following comments.

The report of the whole council attempts valiantly to project medical manpower needs for 1990 in an industry subjected to rapid social change and reform. It introduces a rather advanced "modified needs" methodology in order to meet those sets of projections. While the GMENAC Charter is rather specific with respect to purpose and function, the work we are charged with completing is unfinished. The set of recommendations in the final report is the culmination of our lenghty analysis of <u>available</u> research and of a rather elaborate political process. Suffice to say that with respect to the two panels I served on--Non-Physician and Finance--much more time is needed if further recommendations are to achieve some consistent level of objectivity.

With respect to the role of non-physicians in the health care industry, it is my opinion that increased numbers of non-physicians health care providers does not necessarily aggravate physician supply. The charge of GMENAC in its charter was to evaluate medical manpower needs. Indeed, the original GMENAC Charter does not specifically give GMENAC the right to set rigid levels of participation, job qualifications, or performance evaluation for non-physician

health care providers. GMENAC is not and should not be the final determinant of all health manpower needs in our country. Rather, each discipline should be allowed to evolve and determine its own role in meeting the very real consumer demands for more accessibility in cost effective health care delivery. If in fact GMENAC is permanently established, I believe great care should be taken to better balance council representation as well as to specify its relationship, function, and cooperative role with already existing national advisory councils for nursing and other health professions. After all, medicine is but one component of the health care industry and should not be allowed to write prescriptions for all other health care providers. Each discipline in the health care industry is a vital component to our national goal of quality health care for all people.

While the final report represents limited recommendations regarding the use of non-physician health care providers, that short summary does not provide the details which are available to you in the separate volume covering the work of the non-physician technical panel. It is clear that an important future consideration should be to mandate further research of non-physician utilization and distribution, restrictive state laws, consumer preference, reimbursement, and productivity.

In addition, while the work of our technical panel was directed and deliberately focused on just a few of the existing non-physician providers, a large group of health care providers was unfortunately overlooked in the final report. That group, comprised of the more than one million non-degree registered nurses, does have an immediate effect on health care delivery and a long-term impact on physician supply.

In conclusion, there are no easy answers to the health manpower and health care delivery problems in this country. Long-term solutions developed jointly between the health professions, educational institutions, government, consumers, and the private sector is essential. Volunteerism by the medical profession in regulating their numbers and their

function is difficult to conceptualize in the health care market place which is far from competive. For that reason alone, the work of GMENAC should be continued.

Meeting the mandated national health planning goals is a lofty aspiration requiring more than just minimal intervention in determining first, what are the health needs of our people and second, what types of manpower need to be trained, utilized, and reimbursed in the health care industry in order to meet those needs.

Karen O'Rourke

Karen O'Rourke, RN, MS
GMENAC Member

September 26, 1980

Individual Commentary

Bruce E. Spivey, M.D.
GMENAC Member

Having been a member of GMENAC since its formation, I have had the opportunity to participate in and observe the development of this unique cooperative effort between government and the private sector. This Committee's work has been monumental, and I firmly believe that we have made major progress and innovative contributions to the methodology of forecasting physician supply and requirements. This is not to imply that the task is complete; in fact, far from it! From our studies and deliberations, we have highlighted many areas which are in need of research, further review and refinement. The fact that we have accomplished as much as we have is a tribute to the amazing dedication of the staff as well as many of the GMENAC members. The considerable diversity among the GMENAC members, in both professional training and in philosophical orientation, insured that all sides of the issues were represented; although this often prolonged our discussions and deliberations, conflicting views and opinions were presented and received in a cooperative manner.

I am concerned that the final report be viewed in the proper perspective, namely, that this is a first and extremely preliminary attempt to evaluate and project health manpower supply and requirements in such a totally comprehensive and integrated manner. Therefore, it is essential that this stage of the work not be considered or interpreted as the "final word" when, in fact, this is just the beginning. Both manpower supply and requirements are characteristics of a dynamic system and the estimation of these characteristics must be reassessed periodically with updated assumptions and data in view of this dynamic quality.

The scope of this project and the incredible amount of detail and material involved made it impossible for any member to objectively and comprehensively digest all or even a substantial part of the references, assumptions, implications, calculations, etc. The tremendous pressure to deliver the final report by September 30, 1980, precluded the opportunity for thoughtful and methodical consideration by the Committee of the general and specific implications of the recommendations as summarized in Volume 1. There are recommendations with which I fundamentally disagree. Having been outvoted in a Committee process does not alleviate my deep concern about many problems with the modeling results and the potential for misinterpretation of the Committee's work or misuse of this report as the basis for legislative or regulatory actions.

I strongly caution the reader not to ascribe attributes to the GMENAC modeling projections which they do not possess. The estimates of the specialty-specific numbers of <u>both</u> the projected supply and the projected requirements for 1990 are subject to error, perhaps considerable error. One of the problems is that we do not know how much error; it may be as much as ±20% or more in some or even all cases. For this reason, only the general directions, and <u>not</u> the precise magnitudes, of the imbalances should be considered as credible descriptions of the probable state of affairs in 1990. The methodology and the modeling depend upon the accuracy of the assumptions and the data and can only be validated over time.

A major problem and source of error is the inadequate or incomplete data bases we encountered in so many areas and with regard to most specialty practices. How much error this has contributed to the modeling of the requirements for the various specialties is not known. Further, due to resource limitations, six specialties were not modeled via the Delphi panel approach nor did GMENAC have the opportunity to replicate even one Delphi panel's result in order to provide some estimate of the degree of error that might be associated with this approach.

It is absolutely essential that these projections be continually monitored in the future, recognizing that some of the assumptions will require modifications based on experience. In fact, there are some assumptions which were presented in the Interim Report that have been revised given our experience over the past several years. The reported estimates of supply for each of the specialties provide one example where current assumptions should be modified. First of all, the supply projections assume that there could be nearly unlimited growth to accommodate all of the U.S. and foreign medical graduates, an assumption which is, at least, optimistic. Second, the apportionment of all individuals entering graduate medical education into specialty training positions based on historical trends may have inflated the projected supply in some specialties and underestimated the projected supply in others because it has been assumed that expansion of training programs will occur proportionately for all specialties in estimating the 1990 expected supply.

The medical profession must take serious cognizance of this preliminary report. Hopefully, the profession plus governmental and private agencies will respond by helping to improve the data and by taking the responsibility for objectively evaluating the strengths and weaknesses contained herein. For most specialties, changes in the number of training programs are not warranted until intensive reassessments of the projections are made over the next several years. However, a few of the specialties for which very large imbalances are projected should begin to face the magnitude of the problem now and begin to formulate plans for action. It is clearly the responsibility of the profession, and the specialties in particular, to deal with these problems of numbers and distribution. I firmly believe the private sector can and will be able to deal effectively and appropriately with these issues without the need for regulations or legislation.

In estimating physician requirements for 1990, the calculations are based, in part, on "norms of care." These "norms" represent overall averages which will vary widely among patients. It is totally inappropriate to apply such averages to a specific patient as standards of adequate or indicated medical care required. It is critical that these averages not be misinterpreted and misused by third party payors and others.

Although readers of this report will not find much explicit reference to "quality of care," I cannot emphasize strongly enough that the issue of quality in both education and patient care was a basic and underlying principle of members of the Technical Panel on Modeling, Research and Data. "Quality," while difficult to define in explicit terms, must continue to be a fundamental criterion in health manpower planning for both education and patient care.

Due to resource limitations, the Committee only superficially considered the issue of nonphysician provider supply and requirements. Independent nonphysician providers were basically ignored as the Technical Panel dealt primarily with roles and supply of Nurse Practitioners, Physician Assistants and Nurse Midwives who are formally allied or supervised by physicians. As a result, the Panel had no basis on which to develop recommendations regarding the specific requirements for any such providers. It is imperative that all nonphysician providers be modeled in the same manner as the medical specialties and that the overlap in patient care be incorporated into such an analysis as it has been for adult care and child care medical specialties. Given that the nation is not facing an undersupply in "primary care" specialties, the recommendations which suggest that certain nonphysicians be granted authority to dispense or prescribe drugs should be cautiously evaluated with regard to the adequacy of the pharmacological training that nonphysician providers receive. If such authority is to be granted, it should only be permitted in situations where physician supervision and monitoring are assured and medical necessity exists. Recognizing that there are some states where independent nonphysician providers are legally authorized the limited use of drugs, the advisability of such medically unsupervised practices must also be evaluated.

The major unresolved concern which may impede any voluntary response to the GMENAC projections and implications is one involving the Federal Trade Commission. Assuming that the projections for a large oversupply in a particular specialty are approximately accurate, any attempt to voluntarily restrict the number of training positions available in that specialty could very likely be viewed by the FTC as an antitrust or restraint of trade violation. Therefore, it is imperative that a formal ruling on this issue be made. No action should be expected of any segment of medicine until such a formal ruling is rendered. It is my request, as it has been in GMENAC meetings for the past two years, that the genesis of this request to the FTC originate from the Department of Health and Human Services.

I appreciate the opportunity to comment on the GMENAC process and results. Although I am aware of the weaknesses of certain aspects of the work, there is much that deserves praise and approval. I strongly believe that it is of paramount importance that the work initiated by GMENAC be continued so that the additional research and modeling can be completed, and so that the projections developed at this point in time can be monitored for at least a ten-year period. Although many in the medical profession have seriously questioned the advisability of this Committee's formation and charge, it is <u>now</u> the case that a failure to continue this work as a joint collaboration between the government and the health professions might well have serious negative consequences for medicine and the public sector. If this monitoring, combined with reviewing and refining of the modeling process and revising the assumptions as needed, is not maintained, this entire effort will have limited value and credibility and could even have a negative effect if the results are misunderstood or used for major policy changes.

Bruce E. Spivey, M.D.
GMENAC Member

September 26, 1980

Individual Commentary
Jeanne Spurlock
GMENAC Member

The report of the Graduate Medical Education National Advisory Committee does not fully reflect the complexity of the problems addressed; nor, of the recommendations. In the opinion of the undersigned, the medical service needs of the nation at the time of the completion of the report differ from those identified at the onset of the deliberations. Now, we must be concerned with the health and medical care of the vast numbers of the refugee populations that have arrived in the United States. This reality compounds the problem of providing adequate medical care to the underserved groups of citizens, ranging from the American Indians who live on reservations to residents of inner cities to the poor in the rural areas of the country. These realities prompt questions as to whether or not there is indeed a surplus of physicians, and, if so, is this an asset or a liability to the efforts directed toward the provision of adequate medical care for all who reside in the United States.

The reference to the surplus of physicians notes the shortage among the minority groups. However, reference to the severity of this problem has been lost in the summation. For example, a report of a survey,(Rocheleau, B. "Black Physicians and Ambulatory Care". Public Health Reports, May-June, 93(3):276-82) conducted by the National Center for Health Statistics, includes some highly significant and pertinent findings: "According to the 1970 Census Bureau data, there were only about 6,000 black physicians, both ambulatory care and others, which amounted to approximately 2.1 percent of all physicians." The extremely low percentage of black physicians accounts for the fact that "in absolute terms, most black patients visit non-black physicians" even though in "relative percentages, black physicians are far more likely to serve black patients than non-black physicians."

Obviously, the shortage of minority group physicians in general is reflected in the various specialities. Of particular concern to the undersigned is the alarmingly low numbers of minority physicians who are trained in psychiatry and child psychiatry. Recent studies of the Office of Membership Services and Studies of the American Psychiatric Association have revealed the following significant findings (as of September, 1980): Of a total number of 35,212 practicing psychiatrists in the United States, less than 4000 are minorities (American Indian & Alaskan Native, Asian American & Pacific Islander, Black, Hispanic). The literature is replete with references to the fact that there is an overall shortage of psychiatrists, as noted in the GMENAC report, as well as the particular shortage in the public facilities. Currently, a large percentage of the psychiatric services in the public service programs is provided by foreign medical graduate psychiatrists, a greater proportion of whom are women. It is essential that there be further study to determine how the implementation of the recommendation curtailing the entry of foreign

medical graduates into the medical service system will impact on the care of the mentally ill who are hospitalized in public facilities and/or who are provided care in out-patient public settings.

The responses noted in this brief commentary illustrate the need to look at the full report and all commentaries to be received; to evaluate the possible or probably ripple effects of the implementation of any one of the recommendations prior to the implementation of any.

Jeanne Spurlock
GMENAC Member

September 26, 1980
Date

Individual Commentary
E. LEE TAYLOR
GMENAC Member

The Graduate Medical Education National Advisory Committee (GMENAC) did not sufficiently address the physician manpower requirements of the Department of Defense.

The variable and unique requirements for national defense, such as global medicine and contingency preparedness, as well as the supply and distribution of physicians differ significantly from those of the civilian community. I cannot emphasize this unalterable fact too strongly.

In addition, accurate data collection for formulating meaningful recommendations would involve sensitive areas of national security.

GMENAC recommendations regarding non physician and physician manpower numbers for supply, distribution and education cannot be used to determine Department of Defense requirements.

E. Lee Taylor
GMENAC Member

24 September 1980
Date

INDIVIDUAL COMMENTARY
MARGARITA C. TREVINO, R.N.,M.S.
GMENAC MEMBER

The GMENAC study has clearly pointed out the need for a multidisciplinary team approach, including consumers, to the complex process of health manpower planning in this country. There is an overwhelming need for all health care providers to make concerted efforts to research, to articulate, and to share through cross-disciplinary education and consumer-oriented public information systems the following points of reference:

1: their independent, dependent, and interdependent roles and functions as applicable to the specific discipline;

2: the types of health/illness care services provided;

3: the expected outcomes of the services provided; and

4: the impact of all of the above on the health status of individuals, families, and communities.

With specificity to nonphysician health care providers, this is a timely period in their developmental continuum as providers to become more actively involved in establishing and maintaining their legitimacy in the health care industry and in determining their contributions to quality health and illness care in this country. Only then will GMENAC-like efforts have facts and not feelings to facilitate informed decision-making with increased objectivity. To the contrary, skepticism and negative attitudinal predisposition, not facts, will perpetuate the development of prescriptive rather than collaborative interdisciplinary working relationships between physician and nonphysician health care providers. Only then will the adequate resolution of related public policy dilemmas be successfully addressed.

Due to its charge, the GMENAC focus on the nonphysician health care provider centered primarily on the question of physician service substitutability and delegation of medical care services as these affect physician manpower requirements.

Future studies involving the utilization of nonphysician health care providers must extend beyond the role fulfillment of substitution. There is urgent need for physicians and nonphysician health care providers to give serious attention to how their combined expertise can best be integrated in a complementary fashion to provide a team approach in addressing the health care needs of the American public within the health care delivery structures in this country.

While the GMENAC study raised more questions than it had answers for regarding the nonphysician health care providers, this report can provide the desirable impetus to advance comprehensive and collaborative health manpower planning between physicians, nonphysician health care providers, and consumers with the ultimate goal of improving the health of this nation.

To quote Rubin:

> Trivializing our relationships with each other makes us less responsive to each other and must also make us less responsive to our own needs. If we fail to respond fully to the human situation of others, we will not stimulate and develop our feel for what is most human.
>
> (Rubin)

Margarita C. Trevino

GMENAC Member

September 25, 1980

Date

Rubin, Jerry. "Politics Is How You Live Your Life, Not Whom You Vote For". The Politics of Social Services. Edited by Jeffrey H. Galper.

APPENDIX

GMENAC RECOMMENDATIONS

Each of the preceding six volumes of the Final Report presents a series of recommendations which were formally approved by the Committee. This section of the Appendix contains a complete list of all of these recommendations.

I. RECOMMENDATIONS -- SUMMARY REPORT (VOLUME I)

RECOMMENDATION 1. Allopathic and osteopathic medical schools should reduce entering class size in the aggregate by a minimum of 10 percent by 1984 relative to the 1978-79 enrollment, or 17 percent relative to the 1980-81 entering class.

A. No new allopathic or osteopathic medical schools should be established beyond those with first-year students in place in 1980-81.

B. No increase in the entering class size into allopathic and osteopathic medical schools beyond the entering class of 1981 should occur.

C. The current Health Professions Law, which authorizes grants to health professions schools for construction of teaching facilities, should be amended to allow the Secretary of the Department of Health and Human Services to grant waivers immediately to allopathic and osteopathic medical schools to allow them to ignore the law's requirement to increase enrollment. This recommendation applies as well to the pertinent Veterans Administration authorities under the Manpower Grants Program.

D. The current Health Profesions Law should be amended to allow the Secretary of the Department of Health and Human Services to waive immediately the requirement that allopathic and osteopathic medical schools, as a condition of receiving a capitation grant, maintain the first-year enrollment at the level of the preceding school year. This recommendation applies as well to the pertinent Veterans Administration authorities under the Manpower Grants Program.

RECOMMENDATION 2. The number of graduates of foreign medical schools entering the U.S. yearly, estimated to be 4,100 by 1983, should be severely restricted. If this cannot be accomplished, the undesirable alternative is to decrease further the number of entrants to U.S. medical schools.

A. All Federal and State assistance given through loans and scholarships to U.S. medical students initiating study abroad after the 1980-81 academic year should be terminated.

B. The current efforts in the private sector to develop and implement a uniform qualifying examination for U.S. citizens and aliens graduating from medical schools other than those approved by the Liaison Committee for Medical Education (LCME) as a condition for entry into Liaison Committee for Graduate Medical

Education (LCGME) approved graduate training programs should be supported. Such an examination must assure a standard of quality equivalent to the standard applied to graduates of LCGME accredited medical schools. These U.S. citizens and aliens must be required to complete successfully Parts I and II of the National Board of Medical Examiners' examination or a comparable examination. The Educational Commission for Foreign Medical Graduates (ECFMG) examination should not be used as the basis for measurement of the competence of United States Foreign Medical Graduates (USFMGs) or alien physicians.

C. Alien physicians, who enter the United States as spouses of U.S. citizens, should be required to complete successfully Parts I and II of the National Board of Medical Examiners' examination or a comparable examination prior to entry into residency training.

D. The ability to read, write, and speak English should remain a requirement for graduate medical education programs for all alien physicians.

E. The Federation of State Medical Boards should recommend and the States should require that all applicants successfully complete at least one year of a Graduate Medical Education (GME) program that has been approved by the LCGME and successfully pass an examination prior to obtaining unrestricted licensure. The examination should assure a standard of quality in the ability to take medical histories, to do physical examinations, to carry out procedures, and to develop diagnostic and treatment plans for patients. The standard of quality should be equivalent to graduates of United States medical schools.

F. The States should severely restrict the number of individuals with limited licenses engaged in the practice of medicine. This restriction applies to those practicing independently without a full license and to those practicing within an institution without adequate supervision.

G. The "Fifth Pathway" for entrance to approved programs of graduate medical education should be eliminated.

H. The transfer of U.S. citizens enrolled in foreign schools into advanced standing in U.S. medical schools should be eliminated.

RECOMMENDATION 3. The need to train nonphysician health care providers at current levels should be studied in the perspective of the projected oversupply of physicians.

RECOMMENDATION 4. To correct shortages or surpluses in a manner not disruptive to the GME system, no specialty or subspecialty should be expected to increase or decrease the number of first year trainees in residency or fellowship training programs more than 20 percent by 1986 compared to the 1979 figure.

RECOMMENDATION 5. In view of the aggregate surplus of physicians projected for 1990, medical school graduates in the 1980's should be strongly encouraged to enter those specialties where a shortage of physicians is expected or to enter training and practice in general pediatrics, general internal medicine, and family practice.

RECOMMENDATION 6. Extensive research on the requirements for Nurse Practitioners (NPs), Physician Assistant's (PAs), Nurse-Midwives (NMWs), and other nonphysician providers should be undertaken as soon as possible. Special attention must be given to the effect of a physician excess on their utilization and to the benefits these providers bring to health care delivery. These studies should consider the full range of complementary and substitute services.

RECOMMENDATION 7. Until the studies in Recommendation 6 have been completed, the number of PAs, NPs, and NMWs in training for child medical care, adult medical care, and obstetrical/gynecological care should remain stable at their present numbers. Delegation levels recommended by GMENAC for 1990 are: In obstetrics/gynecology 197,000 of the normal uncomplicated deliveries (5 percent of all deliveries), 7.1 million maternity related visits (20 percent of the obstetrical caseload), and 7.5 million gynecological visits (18 percent of the gynecological caseload); in child care not more than 46 million ambulatory visits (16 percent of the child ambulatory caseload) and in adult medical care not more than 128 million ambulatory visits (12 percent of the adult medical ambulatory caseload).

RECOMMENDATION 8. All incentives for increasing the class size or the number of optometric or podiatric schools should cease until the studies in recommendation 6 have been completed and evaluated.

RECOMMENDATION 9. State laws and regulations should not impose requirements for physician supervision of NPs and PAs beyond those needed to assure quality of care.

A. State laws and regulations should be altered as necessary so that a PA or NP working under appropriate physician supervision can independently complete a patient encounter for conditions which are deemed delegable.

B. The States should provide PAs, NPs, and nurse-midwives with limited power of prescription, taking necessary precaution to safeguard the quality of care including explicit protocols, formularies, and mechanisms for physician monitoring and supervision.

C. At a minimum, PAs, NPs, and nurse-midwives should be given power to dispense drugs in those settings where not to do so would have an adverse effect on the patient's condition.

D. States, particularly those with underserved rural areas, should evaluate whether the laws and regulations pertaining to

nonphysician practice discourage nonphysician location in these areas.

RECOMMENDATION 10. The requirements of third party payors for physician supervision should be consistent with the laws and regulations governing nonphysician practice in the State.

RECOMMENDATION 11. Medicare, Medicaid, and other insurance programs should recognize and provide reimbursement for the services by NPs, PAs, and nurse-midwives in those States where they are legally entitled to provide these services. Services of these providers should be identified as such to third party payors and reimbursement should be made to the employing institution or physician.

RECOMMENDATION 12. NPs, PAs, and nurse mid-wives should be eligible for all Federal incentive programs directed to improving the geographic accessibility of services, including the National Health Service Corps Scholarship Program.

RECOMMENDATION 13. Graduate medical education should be constructed to give residents experience in working with PAs, NPs, and nurse-midwives to insure that these physicians will be prepared to utilize nonphysician services.

RECOMMENDATION 14. GMENAC recommends that the basic unit for medical manpower planning should be a small geographic area within which most of the population receives a specified medical service. These functional medical service areas, service by service, are recommended as the geographic units for assessing the adequacy of manpower supply.

RECOMMENDATION 15. GMENAC encourges the support of efforts within the profession to assess the outcomes of common medical and surgical practices exhibiting high variation across communities. Accomplishing this step would help to establish long-range requirements for physician services in the United States.

RECOMMENDATION 16. Variations between communities in the utilization of specific medical services should be continuously documented and analyzed. The effect of differing financing and organizational arrangements for the delivery of medical care services should be evaluated.

A. Utilization rate experiences, relative to the norms of other physicians practicing in the immediate area, the region, or the nNtion, should be made available to physicians.

B. Future health manpower planning groups should compare manpower estimates, whether derived from need-based, demand-based, or requirements-based models, against empirical estimates selected from areas in the United States exhibiting high and low utilization patterns.

RECOMMENDATION 17. GMENAC recommends that health manpower shortage areas be defined by a minimum service specific physician-to-population ratio and a maximum travel time to service for child care, adult medical care, obstetrical services, general surgical services, and emergency medical services.

A. The minimum acceptable physician-to-population ratio for any area in the U.S. should be 50 percent of the requirements estimated by GMENAC for each type of health service in the Nation as a whole.

B. Maximum travel times to service for 95 percent of the population within a geographic area should be 30 minutes for child care, adult medical care, and emergency medical service; 45 minutes for obstetrical care and 90 minutes for general surgical services.

RECOMMENDATION 18. Alternative data systems for monitoring the geographic distribution of physicians should be developed and evaluated.

RECOMMENDATION 19. Medical students should be encouraged to select a location for practice in underserved rural and urban areas by several approaches: (1) Urban and rural perceptorships should be continued and expanded by those schools having an interest; (2) governmental loan and scholarship programs should be catalogued and evaluated to determine their effectiveness in improving geographic distribution; (3) loan forgiveness programs modeled after those which have been successful should be used, and (4) the National Health Service Corps and its scholarship program should be supported.

RECOMMENDATION 20. The medical profession in making decisions as to residency training programs should consider the aggregate number of programs, their size, and the geographic distribution of their graduates, in additon to the quality of the program, in light of national and regional needs.

RECOMMENDATION 21. Family practice residency training programs should be supported since these programs tend to train providers who are more likely to choose to practice in underserved areas. A similar rationale underlies support needed for resident experiences in underserved areas and for certain nonphysician provider training programs.

RECOMMENDATION 22. Area-wide programs of decentralized medical education and service such as WAMI (Washington, Alaska, Montana, and Idaho), WICHE (Western Interstate Commission for Higher Education), and some AHECs (Area Health Education Centers) should be evaluated for replicability. Such programs have been effective in placement of physicians in sparsely populated areas.

RECOMMENDATION 23. More research and evaluation should be conducted on factors relating to the geographic distribution of physicians.

RECOMMENDATION 24. Medical education in the medical schools and in the early phase of graduate medical education in the teaching hospitals should provide a broad-based clinical experience with empahasis on the

generalist clinical fields. A portion of graduate medical training should occur in other than tertiary care medical centers.

RECOMMENDATION 25. A more vigorous and imaginative emphasis should be placed on ambulatory care training experiences.

A. The outpatient services of the academic medical centers should be upgraded through special project grants.

B. Educational innovation in outpatient settings should be fostered by providing financial support

C. Faculty should be encouraged and supported to develop careers focused on ambulatory medicine through a career development award mechanism.

RECOMMENDATION 26. Greater diversity among the medical students should be accomplished by promoting more flexibility in the requirements for admission; by broadening the characteristics of the applicant pool with respect to socioeconomic status, age, sex, and race; by providing loans and scholarships to help achieve the goals; and by emphasizing, as role models, women and underrepresented minority faculty members.

RECOMMENDATION 27. Information about physician manpower needs in the various specialties and in different geographic settings should be disseminated broadly to medical schools, administrators, faculty, and medical students, residents, fellows, and spouses.

RECOMMENDATION 28. Capitation payments to medical schools for the sole purpose of increasing class size or for influencing specialty choice should be discontinued in view of the impending surplus of physicians.

RECOMMENDATION 29. Special purpose grants to medical schools and other teaching institutions for primary care training in family medicine, general internal medicine, and general pediatrics should be continued in order to continue and to increase the emphasis on primary care services and ambulatory care.

A. Family practice programs, at least for the near term, should be given special attention in view of the difficulty in financing training programs from ambulatory care revenues.

B. Specialties in short supply should be considered for special project grants.

RECOMMENDATION 30. Ambulatory care training should be promoted further by the provision of grants for renovation and construction of facilities, for the support of training programs in ambulatory sites, and for student preceptorships and residency experiences in out-of-hospital care.

RECOMMENDATION 31. The medical profession, having the major responsibility for correcting physician oversupply, should ensure the quality of all graduate medical education programs and full funding of

these programs through reimbursement should be given only to accredited programs when mechanisms are in place.

RECOMMENDATION 32. Calculations of the true costs of graduate medical education should include the compensation for residents and teaching personnel and all of the ancillary and indirect costs, and should distinguish between the cost of education and the cost of patient care by a uniform recognized reporting system. Costs should be borne equitably by all payors as part of the normal rate structure for patient care costs at the teaching hospitals, clinics, and other sites where health services and training are provided, to the extent that such costs are not financed by tuition, grants, or other sources of revenue.

RECOMMENDATION 33. The health professions should assume a major responsibility for cost containment in new program development, in accreditation and certification, and in the provision of health services.

RECOMMENDATION 34. Public and private reimbursement policies should be adjusted to: Emphasize ambulatory care services and training; encourage practice in underserved areas; explore the concept of shared risk among physicians, and pay professional fees to teaching physicians when their services have been identifiably discrete and necessary.

RECOMMENDATION 35. Continuous monitoring and evaluation of existing and new financial programs should be supported. Actions undertaken to alter financing and reimbursement strategies should not be advanced as permanent mechanisms for change until adequate evaluation/demonstration efforts have been performed.

RECOMMENDATION 36. Additional research should be accomplished on a broad array of topics related to financial considerations.

RECOMMENDATION 37. Special project grants for States on a cost-sharing basis should be considered to influence the geographic distribution of physicians within the States. The development of incentives for practice in underserved areas is one program to be considered.

RECOMMENDATION 38. The development of future medical faculty, administrators, and researchers should be assured by provision of adequate financial support for their training.

RECOMMENDATION 39. A successor to the Graduate Medical Education National Advisory Committee should be established by statute. This successor should be an advisory body without regulatory functions.

RECOMMENDATION 40. In addition to the continuous monitoring, the supply projections, requirements estimates, and recommendations of GMENAC in their entirety must be reevaluated and modified at least every five years to take account of changes in data, assumptions, and priorities occurring over time.

II. RECOMMENDATIONS — MODELING, RESEARCH AND DATA TECHNICAL PANEL (VOLUME II)

RECOMMENDATION 1. No new allopathic or osteopathic medical schools should be established beyond those with first-year students in place in 1980-81.

RECOMMENDATION 2. There should be no increase in the entering class size into allopathic and osteopathic medical schools beyond the entering class of 1981.

RECOMMENDATION 3. Allopathic and osteopathic medical schools should reduce entering class size in the aggregate by a minimum of 10 percent by 1984 relative to the 1978 figure.

RECOMMENDATION 4. The current health professions law, which authorizes grants to health professions schools for construction of teaching facilities, should be amended to allow the Secretary of the Department of Health and Human Services to grant waivers immediately to allopathic and osteopathic medical schools to allow them to ignore the law's requirement to increase enrollment. This recommendation applies as well to the pertinent Veterans Administration authorities under the Manpower Grants Program.

RECOMMENDATION 5. The current health professions law should be amended to allow the Secretary of the Department of Health and Human Services to waive immediately the requirement that allopathic and osteopathic medical schools, as a condition of receiving a capitation grant, maintain the first-year enrollment at the level of the preceding school year. This recommendation applies as well to the pertinent Veterans Administration authorities under the Manpower Grants Program.

RECOMMENDATION 6. The number of graduates of foreign medical schools entering the U.S. yearly, estimated to be 4,100 by 1983, should be severely restricted. If this cannot be accomplished, the undesirable alternative would be to further decrease the number of entrants to U.S. medical schools.

RECOMMENDATION 7. Terminate all Federal and State assistance given through loans and scholarships to U.S. medical students initiating study abroad after the 1980-81 academic year.

RECOMMENDATION 8. Endorse current efforts in the private sector to immediately develop and implement a uniform qualifying examination for administration to U.S. citizens and aliens who graduated from medical schools other than those approved by the LCME, for entry into LCGME approved graduate training programs.

A. Such an examination must assure a standard of quality equivalent to the standard applied to graduates of LCME-accredited medical schools.

B. Specifically, such U.S. citizens and aliens must be required to successfully complete Parts I and II of the National Board of Medical Examiners examination or a comparable examination.

C. It is specifically recommended that the ECFMG examination not be used as the basis for measurement of the competence of USFMGs or alien physicians.

RECOMMENDATION 9. Require that alien physicians who have entered the United States on the basis of being spouses of U.S. citizens successfully complete Parts I and II of the National Board of Medical Examiners examination, or a comparable examination, prior to entry into residency training.

RECOMMENDATION 10. Ability to read, write and speak English should remain a requirement for graduate medical education programs for all alien physicians.

RECOMMENDATION 11. Urge the Federation of State Medical Boards to recommend (and the States to require) that, prior to obtaining unrestricted licensure, all applicants must have successfully completed at least one year of a GME program which has been approved by the LCGME and must have successfully passed an examination which assures a standard of quality, particularly in the ability to take medical histories, do physical examinations, carry out procedures, and develop diagnostic and treatment plans for patients, equivalent to the standard applied to graduates of United States medical schools.

RECOMMENDATION 12. Urge the States to restrict severely the number of individuals engaged in the practice of medicine who do not have an unlimited license. This applies to those practicing independently without a full license and to those practicing within an institution without adequate supervision.

RECOMMENDATION 13. Eliminate the "Fifth Pathway" for entrance to approved programs of graduate medical education.

RECOMMENDATION 14. Eliminate the transfer of U.S. citizens enrolled in foreign medical schools into advanced standing in United States medical schools.

RECOMMENDATION 15. In view of the projected oversupply of physicians, the need to train nonphysician health care providers at current rates should be studied.

RECOMMENDATION 16. In view of the aggregate surplus of physicians projected in 1990, medical school graduates in the 1980s should be strongly encouraged to: (1) Enter training in those specialties where a shortage of physicians is expected, and (2) enter training in the generalist fields of family practice, general pediatrics, and general internal medicine.

RECOMMENDATION 17. To correct shortages or surpluses in a manner which would not be disruptive to the GME system, no specialty or subspecialty should be expected to increase or decrease the number of first-year trainees in residency or fellowship training programs more than 20 percent by 1986, compared to 1979.

III. RECOMMENDATIONS — GEOGRAPHIC DISTRIBUTION TECHNICAL PANEL (VOLUME III)

RECOMMENDATION 1. The functional medical service areas, specialty by specialty, are recommended as the geographic unit for assessing availability of physician services. The Graduate Medical Education National Advisory Committee (GMENAC) also recommends that physician market areas by specialty be determined empirically based on patient origin data derived from such information as discharge and claims data, until such time as total enumeration of physician services is possible, and that the resulting areas be compared to those previously determined by specialty societies.

RECOMMENDATION 2. GMENAC supports the evaluation of alternative data systems for the monitoring of the geographic distribution of providers.

RECOMMENDATION 3. GMENAC urges the use of small area population-based data on the availability, requirements for and utilization rates of hospital and physician services as a manpower planning tool.

RECOMMENDATION 4. GMENAC urges that the ranges of variations in the utilization of specific procedures and services among service populations and communities be collected and analyzed (including communities with differing financing and organizational arrangements for the delivery of medical care services).

RECOMMENDATION 5. Serious attention should be given to making available to physicians their utilization rate experiences relative to the norms of other physicians practicing in their immediate area, region, or in the Nation.

RECOMMENDATION 6. Serious attention should be given to the voluntary collection and dissemination for analytical purposes of aggregate statistics relative to utilization rates in various service areas.

RECOMMENDATION 7. GMENAC encourages the support of efforts within the profession to assess the outcomes of common medical and surgical practices which exhibit high variation across communities as an important step for establishing the long-range requirements for suppliers of medical services in the United States.

RECOMMENDATION 8. Future health manpower planning groups should compare manpower estimates (whether derived as a needs-based, demand-based or requirements-based model) against empirical estimates selected from areas in the United States which exhibit high and low utilization patterns.

RECOMMENDATION 9. GMENAC recommends that five basic types of health care services should be available within some minimum time/access standards: Adult medical care; child care; obstetrical services; surgical services, and emergency services. In order to monitor the geographic distribution

of physicians, GMENAC recommends that a minimum acceptable physician-to-population ratio for all areas in the U.S. be established. It is recommended that 50 percent of the GMENAC Modeling Panel ratio of physician specialists per 100,000 for 1990 be established as the minimum acceptable ratio for all areas.

RECOMMENDATION 10. GMENAC recommends maximum travel times of 30 minutes for emergency medical care, 30 minutes for adult medical care, 30 minutes for child medical care, 45 minutes for obstetrical care, and 90 minutes for surgical care services for 95 percent of the population in 1990, recognizing that unusual circumstances may arise which make these travel times impossible to achieve for all areas.

RECOMMENDATION 11 GMENAC recommends that the definition of health manpower shortage area include minimum physician/population ratios and a minimum travel time-to-service for general surgery, emergency medical services, and obstetrical services.

RECOMMENDATION 12. Incomplete information exists on the direction of causation of many of the factors affecting physician location. Additional research is needed to study: (1) How background factors such as sociodemographic factors affect specialty and location choices and the interaction between specialty and location choices and, (2) what factors affect permanent location choices in underserved/rural areas.

RECOMMENDATION 13. Since the role of economic factors in location choice is not clear, attempts should be made to improve methodologies to determine this role and to gather data on previously nonquantifiable topics such as income as a motivating force in specialty or location choices.

RECOMMENDATION 14. Those strategies which GMENAC deemed most promising, such as preceptorships and tax incentives, and those which are most amenable to evaluation efforts, should be evaluated more vigorously.

RECOMMENDATION 15. There is some evidence that selective admissions policies may improve the geographic distribution of physicians. A nationally mandated alteration in admission policies is not recommended at this time; further study into the location decisions of students with particular ethnic or sociodemographic characteristics is recommended.

RECOMMENDATION 16. Economic incentives (such as tax credits and deductions) and/or the provision of higher payment levels for services as an inducement for physicians to practice in underserved areas should be explored.

RECOMMENDATION 17. Demonstration projects should be developed and evaluated to determine the impact of differential rates of reimbursement for technology-intensive versus time-intensive (counseling, patient education) services upon the geographic distribution of physicians and services.

RECOMMENDATION 18. It is recommended that practicing physicians and faculty convey to students that the practice of medicine can be delivered in a variety of geographic settings, including both rural and urban shortage areas. As a means of accomplishing this, urban and rural preceptorships for medical students should be continued and expanded in schools with an interest in monitoring such programs.

RECOMMENDATION 19. Given the geographic distributional patterns of family practitioners, graduate medical education programs in family medicine should continue to be supported as a strategy to increase primary care services in certain geographic areas of underservice.

RECOMMENDATION 20. Incentives should be created to broaden residency education experiences to encompass training in underserved areas, provided the appropriate resources are available and standards of education of the relevant accrediting body are met.

RECOMMENDATION 21. Data suggest that nonphysician health care providers favorably affect the distribution of medical services by their tendency to select shortage area locations more frequently than is the case with physicians. It is recommended that nonphysician health care provider training programs should continue to be supported for this reason.

RECOMMENDATION 22. Decentralized medical education programs such as WAMI (in Washington, Alaska, Montana, and Idaho) and WICHE (Western Interstate Commission for Higher Education) were developed to coordinate medical education and placement programs in a relatively isolated and sparsely populated region. These types of programs have been effective and attention should be given to their replicability.

RECOMMENDATION 23. GMENAC encourages the medical profession, through its training program directors and various specialty societies, in making decisions as to residency training programs, to consider, in addition to the quality of residency programs, the aggregate number of programs, their size, and the geographic distribution of their graduates to meet national and regional needs.

RECOMMENDATION 24. The National Health Service Corps (NHSC) and the NHSC Scholarship Program for increasing the availability of primary care physician services in designated health manpower shortage areas impact favorably on the geographic distribution of physicians; therefore, the NHSC and the NHSC Scholarship Program should continue to be supported.

RECOMMENDATION 25. Governmentally sponsored loan and scholarship programs should be catalogued and evaluated to determine their effectiveness in improving the geographic distribution of physicians.

RECOMMENDATION 26. Despite limited evaluation, there is evidence that several AHEC (Area Health Education Centers) models are effective in inducing physicians to pratice in underserved areas and/or to practice primary care. These types of AHECs should receive continued support.

RECOMMENDATION 27. Loan forgiveness programs modeled after those which have been successful should be used as a strategy for attracting physicians into underserved areas.

RECOMMENDATION 28. Comprehensive evaluation of programs to recruit and retain providers in underserved areas (e.g., Rural Health Initiative, Rural Health Clinics, Health Underserved Rural Area Program) should be performed after a reasonable period of time. Continued funding of these programs should be contingent upon a positive evaluation of their effectiveness.

RECOMMENDATION 29. Programs that foster or support group practice arrangements in rural area, coupled with the appropriate communication and transportation networks, should be developed or established on an experimental basis as a means of attracting physicians to rural communities. If these delivery modes prove to be successful in delivering care to underserved areas, start-up funding should be encouraged for new programs.

RECOMMENDATION 30. Discontinuation of geographic differentials in payment levels of third-party payors when this is in excess of differences in costs of delivering those services as a means of influencing geographic distribution should be the subject of future research. Present reimbursement systems (Federal, State and private) tend to sustain historical differences in fees and incomes among geographic areas and thus provide incentives for physicians to locate in high income communities within metropolitan areas.

RECOMMENDATION 31. GMENAC recommends that all physicians, both those in primary care specialties and those in nonprimary care specialties, be reimbursed at the same payment level for the same primary care services.

IV. RECOMMENDATIONS — FINANCING TECHNICAL PANEL (VOLUME IV)

RECOMMENDATION 1. In view of an oversupply of physicians by the year 2000, any increase in medical school enrollment beyond current aggregate levels should be discouraged.

RECOMMENDATION 2. Capitation payments to medical schools for the sole purpose of influencing specialty choice or for increasing class size should be discontinued (or phased out should financial conditions of institutions warrant a time-phased approach to termination).

RECOMMENDATION 3. Special purpose grants to support undergraduate and graduate medical education programs should be used to accomplish specific goals in special circumstances and can be an important, effective, and appropriate means of influencing the supply and distribution of physicians.

RECOMMENDATION 4. Special purpose grants to medical schools and other teaching institutions for primary care training in family medicine, general internal medicine, and general pediatrics should be continued.

- Project grants for graduate and undergraduate programs in these specialties should be continued in order to continue emphasis upon ambulatory care needs.
- Family practice programs, at least for the short term, should be given special attention.
- Specialties determined to be in short supply should be considered for special project grants as well.
- Plans for the subsidy of any new specialty programs, if deemed appropriate, should include an analysis of their needs for long-term support.

RECOMMENDATION 5. Grants should be provided for the selective renovation and construction of ambulatory facilities in training institutions as well as for the establishment and support of training centers located in these facilities.

RECOMMENDATION 6. Grants should be made available for the support of student preceptorships and residency experiences in ambulatory settings (especially in areas of clear underservice).

RECOMMENDATION 7. Financial grants and aid without future service obligation should be continued for first-year medical students of exceptional financial need and for those students who are from underrepresented ethnic groups. Such support should be extended to cover the second year of medical school for these students.

RECOMMENDATION 8. Financial grants and aid with future service obligations and student loans with forgiveness provisions should be continued.

RECOMMENDATION 9. Consideration needs to be given to the development of an improved Government loan program that would permit students to finance their own medical education.

RECOMMENDATION 10. To the extent that any specialties are determined to be in or will reach undersupply or oversupply, the private sector should develop methods to remedy this situation, working as needed with Government at all levels.

RECOMMENDATION 11. The private sector should take steps to ensure the quality of graduate medical education programs. When mechanisms are in place, consideration should be given to full financing and reimbursement only for approved programs.

RECOMMENDATION 12. The costs of graduate medical education should include compensation for residents as well as teaching personnel; education support services, such as the costs of library and audiovisual services; the costs of administering the program; and indirect costs such as plant depreciation, cafeteria and laundry services, administrative services, etc., ascribable to the teaching program.

RECOMMENDATION 13. A uniform recognized reporting system should be developed to permit meaningful cost accounting distinctions between graduate medical eduction and patient care costs.

RECOMMENDATION 14. The costs of GME should be borne equitably by all payors as part of the normal rate structure for patient care costs at the teaching hospitals, clinics, and other sites where health services and training are provided, to the extent that such costs are not financed by tuition, grants or other sources of revenue.

RECOMMENDATION 15. Cost considerations should be given explicit and prominent attention in any proposals to change the standards and processes of accreditation in graduate medical education, the length of training, certification requirements, and proposals to initiate new types of training programs and develop new specialties.

RECOMMENDATION 16. With respect to new and existing training programs, the Committee believes that administrators, faculty, and residents must exercise a clear and strong responsibility to continually seek and implement opportunities for cost-savings in health care within an overall context of balancing quality, cost, and access considerations.

RECOMMENDATION 17. Adequate financial support must be provided for programs directed towards the development of future medical faculty, administrators, and researchers.

RECOMMENDATION 18. Public and private reimbursement policies should be adjusted and mechanisms identified to provide incentives for physicians to:

-- Emphasize ambulatory care

-- Practice in geographic areas which are medically underserved.

RECOMMENDATION 19. Public and private sector dialog focusing on health insurance options or reimbursement policies should explicitly consider the implications for physician specialty and geographic distribution of any proposals to alter payment policy and practice. The concept of shared risk among physicians should clearly be given emphasis in such explorations.

RECOMMENDATION 20. A number of principles regarding the payment for services in teaching hospitals should be adopted by third-party payors. They include recognition of the need to compensate services to patients rendered by residents and supervising physicians that are necessary for the care of patients. Payment policies should avoid duplicate payment for services rendered; compensate teaching physicians when they have rendered personal and identifiable medical services or have personally managed the provision of care to a patient while engaged in supervising and/or instructing residents; and compensate professional services on an equitable basis.

RECOMMENDATION 21. A more adequate reimbursement system for physicians' services in ambulatory and outreach settings should be developed to facilitate educational experiences in such settings.

RECOMMENDATION 22. Special project grants for States on a cost-sharing basis should be considered for programs to influence the distribution of physicians within the States. Consideration should particularly be given to the development of incentives for practice in underserved areas, which would be jointly sponsored among governmental levels.

RECOMMENDATION 23. In view of the current state-of-the-art concerning the knowledge base on reimbursement/financing issues, additional research in this area is warranted and should be encouraged. Among the many research questions the following should be pursued:

-- Studying the differential cost, effects on program quality, and the relative effectiveness in meeting physician manpower needs of increased graduate medical education and training in out-of-hospital settings (e.g., physicians' offices, HMOs, Public Health Departments, etc). This will require additional knowledge regarding the (marginal) costs and revenues and the effect of government subsidy attendant to such programs, as well as the relationship to "essentials" and accreditation of training programs.

-- Determining differential costs of each existing financing strategy in achieving goals in distribution of residency positions by specialty.

-- Investigating the impact of financial incentives on pubic versus private training institutions.

-- Developing and evaluating demonstration projects for collection and feedback of statistics relative to community wide fees and payment practices on a specialty and condition-specific basis

-- Examining the relationship of medical students' indebtedness and characteristics to ultimate career choice

-- Evaluating the implications on health manpower of reimbursement for services provided by nonphysicians on an independent free-standing basis

-- Studying the variations in medical practice provided by different medical specialties for the same or similar disease conditions, in the context of relative costs, long-term outcome studies, and cost benefit.

RECOMMENDATION 24. An ongoing mechanism needs to be developed to carefully monitor and evaluate the impact of existing and new economic incentives and disincentives targeted to medical education and practice. Actions undertaken to alter financing and reimbursement strategies should not be advanced as permanent mechanisms for change until adequate evaluation/demonstration efforts are first performed.

V. RECOMMENDATIONS -- EDUCATIONAL ENVIRONMENT TECHNICAL PANEL (VOLUME V)

RECOMMENDATION 1. The applicant pool must be broadened with regard to students' individual characteristics, i.e., socioeconomic status, age, sex, and race.

RECOMMENDATION 2. In an attempt to increase the diversity of individuals entering medicine, GMENAC believes that there must be more flexibility in the requirements for admission to medical school.

RECOMMENDATION 3. The admission process should be examined in the light of national, regional, and local requirements, and the institutional mission.

RECOMMENDATION 4. Education within the medical school should be broad-based and should prepare the student for graduate medical education. GMENAC recommends that there be made available:

A. Project grants to upgrade outpatient services of academic medical institutions to make ambulatory facilities financially viable;

B. Grants to foster educational innovation with respect to education in an ambulatory setting;

C. Suitable faculty reimbursement for ambulatory care;

D. Grants for development of faculty who are competent to teach in the ambulatory setting, and

E. An increased availability of sophisticated career counseling for the student.

RECOMMENDATION 5. GMENAC recommends that the first year of graduate medical education (PGY-1) be a broad-based clinical experience to serve as the foundation for further specialty training.

RECOMMENDATION 6. Information strategies are needed in this area, as well as more role models and medical educational experiences at both the undergraduate and graduate levels, to make residents aware that medicine can be practiced in other than tertiary care centers.

RECOMMENDATION 7. Along the entire educational continuum, medical school applicants, students, students' spouses, administration, and faculty should be continuously provided with information regarding physician manpower needs in the various specialties and different geographic locations (through publications, workshops, or other communication methods).

RECOMMENDATION 8. Programs which will increase the participation and visibility as academic role models of women and underrepresented minorities should be instituted.

RECOMMENDATION 9. To reduce the financial barriers to medical education which are restrictive to diversity, programs of loans and scholarships should be expanded.

VI. RECOMMENDATIONS — NONPHYSICIAN HEALTH CARE PROVIDERS TECHNICAL PANEL (VOLUME VI)

PRINCIPLE 1. Even in the event that there is an adequate number or surplus of physicians in a particular specialty, the use of nonphysician providers (NPs, PAs or nurse-midwives) may be supported for one or more of the following reasons:

1. When they increase the accessibility of services;

2. When they decrease the costs or expenditures associated with health care delivery;

3. When they are the providers of choice for some consumers;

4. When the utilization of nonphysicians increases the quality of service, i.e., services provided by a team composed of a physician and nonphysician are superior to those which a physician working alone could provide.

PRINCIPLE 2. The services which have been included in the GMENAC model are medical services and, if provided by NPs or PAs, these must be done under the supervision of a physician.

PRINCIPLE 3. Nurse-midwives should practice interdependently in a health care delivery system and with a formal written alliance with an obstetrician, or another physician, or a group of physicians who has/have a formal consultation arrangement with an obstetrician/gynecologist.

PRINCIPLE 4. Patients, physicians, and nonphysician health care providers should jointly determine the extent of nonphysician health care provider involvement in care. The health care system should evolve in ways which enhance the opportunity for patients to assume a larger control of their health destinies.

RECOMMENDATION 1. A careful and thorough study of the requirements for NPs, PAs, and nurse-midwives should be undertaken as soon as possible. Special attention must be given to the effect of a physician excess on their utilization and the benefits which these providers might bring to health care delivery. (See Recommendation #12.) The study should consider the full range of services which they provide, both those which are complementary to and those which are substitutes for physician services.

RECOMMENDATION 2. Until the study recommended above (#1) can be completed, the numbers of PAs, NPs, and nurse-midwives being graduated from educational programs each year should continue at their present levels. These numbers are needed to attain the delegation levels which have been deemed desirable by the GMENAC. The Committee recognizes the preliminary nature of these judgments and the need for further data.

Incentives for increasing the numbers trained each year should be discontinued until it has been determined that such numbers are desirable and that they will be utilized in the system.

RECOMMENDATION 3. Federal and nonfederal funding policies for NP, PA, and nurse-midwifery training programs should be reassessed in light of recommendations 1 and 2.

RECOMMENDATION 4. Until the study recommended above (#1) is completed, the numbers of nonphysician providers for obstetrics-gynecology being graduated from educational programs each year should continue at the present levels.

RECOMMENDATION 5. Five percent of the normal, uncomplicated deliveries (197,600) should be delegated to nurse-midwives in 1990.

RECOMMENDATION 6. Delegation of ambulatory visits in obstetrics-gynecology should be adjusted to match the capabilities of the expected supply of nonphysician providers in 1990.

RECOMMENDATION 7. Until the study recommended above (#1) can be completed, the numbers of nonphysicians for child medical care being graduated from educational program each year should continue at their present levels.

RECOMMENDATION 8. The number of visits delegated in child medical care should be adjusted to match the capabilities of the expected supply of nonphysicians in this area in 1990.

RECOMMENDATION 9. Until the study recommended above (#1) can be completed, the numbers of nonphysicians for adult medical care being graduated from educational programs each year should continue at the present levels.

RECOMMENDATION 10. The numbers of visits delegated in adult care should be adjusted to match the capabilities of the expected supply of nonphysicians in this area in 1990.

RECOMMENDATION 11. The continued appropriateness of these specialty-specific delegation recommendations should be thoroughly and carefully reviewed within the next two to three years.

RECOMMENDATION 12. Additional data collection, research, and analysis must be undertaken with regard to the following in order to support future medical manpower planning efforts and more accurately project future requirements for physicians, PAs, NPs, and nurse-midwives.

1. The effect of a physician excess on nonphysician utilization.

2. The geographic distribution of nonphysicians and their contribution to increased service accessibility, particularly in underserved areas.

3. The relative costs and expenditures of using nonphysicians in place of physicians for selected medical care services. The limits of consumer preference for and acceptance of non-physician providers; the reasons for such preference.

5. The distinctive features, if any, of the care given by non-physicians and their relationship to outcome.

6. The short- and long-term professional longevity of nonphysician providers.

7. The specialty distribution of PAs and NPs.

8. The determinants of nurse-midwifery participation in clinical practice.

9. The optimal productivity of nonphysicians with respect to medical services, including differential productivity by provider-type (PA or NP) and by specialty of practice.

RECOMMENDATION 13. State laws and regulations should not impose requirements for physician supervision of NPs and PAs, beyond those needed to assure quality of care.

a) State laws and regulations should be altered as necessary such that a PA or NP working under appropriate physician supervision can independently complete a patient encounter for conditions which are deemed delegable;

b) The States should move to provide PAs, NPs, and nurse-midwives with limited powers of prescription, taking what precautions are necessary to safeguard the quality of care including explicit protocols, formularies, and mechanisms for physician monitoring and supervision;

c) At a minimum, PAs, NAs, and nurse-midwives should be given power to dispense drugs in those settings where not to do so would have an adverse effect on the patient's condition. Precautions as elaborated in #13b above should be taken to safeguard quality of care, and

d) States with underserved rural areas, in particular, should evaluate whether the laws and regulations pertaining to nonphysician practice discourage nonphysician location in these areas.

RECOMMENDATION 14. Medicare, Medicaid, and other insurance programs should recognize and provide reimbursement for the services provided by NPs, PAs, and nurse-midwives in those States where they are legally entitled to provide these services. Services of these providers should be identified as such to third party payors and reimbursement should be made to the employing institution or physician.

RECOMMENDATION 15. The requirements for physician supervision imposed by third party payors should be consistent with the laws and regulations governing nonphysician practice in the States.

RECOMMENDATION 16. Graduate medical education should be structured so as to give residents experience in working with PAs, NPs, and nurse-midwives such that, once in practice, they will be more disposed and better prepared to utilize these providers.

RECOMMENDATION 17. The effect of the size of the physician supply on nonphysician utilization should be studied.

RECOMMENDATION 18. NPs, PAs, and nurse-midwives should be eligible for all Federal incentive programs directed to improving the geographic accessibility of services, including the National Health Service Corps scholarship program.

RECOMMENDATION 19. Consideration should be given to using PAs and NPs to provide some of the services which residents provide, should a decrease in the number of surgical residents occur.

RECOMMENDATION 20. It is imperative that the size of the need for optometric services be ascertained in order to assure that the numbers being trained will not result in an oversupply. Until this study is completed, all incentives for increasing the number of optometric schools or class sizes should cease.

RECOMMENDATION 21. The national requirements for clinical psychologists, psychiatric social workers, and psychiatric nurse clinicians should be formally studied. The possibility of utilizing nonphysicians to cover a portion of the service deficit expected in 1990 due to a shortage of psychiatrists should be examined.

RECOMMENDATION 22. The actual and potential roles of nonphysician providers should be examined for the following specialty areas: anesthesiology, emergency medicine, neurology, nuclear medicine, pathology, physiatry, radiology, and preventive medicine.

RECOMMENDATION 23. A study must be undertaken to determine the national need for podiatrists. Until this study is completed, incentives for new podiatry schools or increasing class size should cease.

RECOMMENDATION 24. In addition to the research agenda proposed above (#12), research and analysis are recommended in the following areas to provide additional empirical backing for future medical manpower planning efforts:

1. The extent and nature of present PA involvement in surgical care and the potential for increased delegation in these specialties.

2. The potential for full visit delegation to PAs and NPs in dermatology.

3. The distinction or similarity in roles between psychiatrists and clinical psychologists, psychiatric social workers, and psychiatric nurse clinicians with respect to the kinds of conditions seen, the interventions taken, and the outcome.

4. The nature and extent of overlap in the practices of podiatrists and dermatologists and podiatrists and orthopedic surgeons.

5. The desirability and feasibility of using an ophthalmologist versus an optometrist for refractive error care.

6. The upper limit of delegability in the various specialties.

7. The comparative health system effects of task and whole visit delegation.

8. The content of care in nursing practice and its overlap with medicine; in particular, conditions seen, services given, outcomes, and legal authority.

9. The efficiency and effectiveness of utilizing NPs and PAs in complementary roles to the physician as part of a team approach to health care.

10. The minimal adequate supervision needed to assure quality of care provided by PAs and NPs.

11. The optimal number of NPs or PAs that can be supervised by one physician.

12. The health system effects, both negative and positive, of direct reimbursement to nurse-midwives.

13. Identification of how present reimbursement policies act to limit utilization of NPs, PAs, and nurse-midwives and the development of appropriate reforms.

CROSS REFERENCE OF GMENAC RECOMMENDATIONS

Each of the preceding volumes of the Final Report contain a series of recommendations which were formally approved by the Committee. Major and supportive recommendations presented in the Summary Report (Volume 1) represent a condensation of the individual recommendations presented in the Technical Panel Reports (Volumes 2-6). The following Cross Reference relates the recommendations presented in the Summary Report with those presented in the Panel Reports. Recommendation numbers correspond to the numbers provided in the preceding six volumes.

Cross Reference of GMENAC Recommendations

GMENAC Summary Recommendations (VOL 1)	GMENAC Panel Recommendations				
	Modeling (VOL 2)	Nonphysician Providers (VOL 6)	Geographic Distribution (VOL 3)	Educational Environment (VOL 5)	Financing (VOL 4)
1	3				
1a-1d	1,2,4,5				
2	6				
2a-2h	7-14				
3	15	17			
4	17				
5	16				
6		1,12,20-24			
7		2-11			
8		20-23			
9		13			
9a-9d		13a-13d			
10		15			
11		14			
12		18			
13		16			
14			1,3		
15			7		
16			4,6		
16a-16b			5,8		
17			11		
17a-17b			9-10		
18			2,12,13		
19			18,24,25,27		8
20			23		
21			19,20,21		
22			22,26		
23			14-17;28-31		
24				4,5,6	
25				4	21
25a-25c				4	
26				1,2,3,8,9...	7
27				7	
28					1,2
29					3,4
29a-29b					4
30					5,6
31					11
32					12,13,14
33					15,16
34					18,19,20
35					24
36					9,23
37					22
38					17
39[1]					
40[1]					

[1] In Summary Report only.

OFFICIAL GMENAC VOTES ON FINAL REPORT VOLUMES

The Committee, sitting in plenary session, voted separately on each of the preceding six volumes of the Final Report. Reports of the Financing and Educational Environment Panels (Volumes IV and V, respectively) were formally approved at the July 27-29, 1980 plenary session. Reports of the Geographic Distribution and Nonphysician Health Care Providers Panels (Volumes III and VI, respectively) were formally approved at the September 2-3, 1980 plenary session. The Committee formally approved the Summary Report (Volume I) and the Modeling Panel Report (Volume II) at its plenary session on September 22-23, 1980.

OFFICIAL GMENAC VOTES ON FINAL REPORT VOLUMES

Report Volume and Title	Date of Vote (1980)	Approve	Disapprove	Abstain
I. Summary Report	September 23,	17	0	1
II. Modeling, Research, and Data Technical Panel	September 23,	16	0	2
III. Geographic Distribution Technical Panel	September 2,	10	3	1
IV. Financing Technical Panel	July 29,	18	0	0
V. Educational Environment Technical Panel	July 27,	17	0	0
VI. Nonphysician Health Care Providers Technical Panel	September 2,	15	0	1

Note: Twelve Committee members are necessary for a quorum.

C H A R T E R

GRADUATE MEDICAL EDUCATION NATIONAL ADVISORY COMMITTEE

The Committee was first chartered by the Secretary of the then Department of Health, Education, and Welfare on April 20, 1976. GMENAC was rechartered for a two year period on May 1, 1978. The Secretary of the Department of Health and Human Services formally extended the charter of the Committee on March 6, 1980, for a period through September 30, 1980.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

C H A R T E R

GRADUATE MEDICAL EDUCATION NATIONAL ADVISORY COMMITTEE

Purpose

The Secretary and, by delegation, the Assistant Secretary for Health are charged under Title VII of the Public Health Service Act with responsibility for taking national leadership in the development of programs addressed to graduate medical education and in the research, development, and analysis for programs that impact on the health manpower needs of this Nation. The purpose of this Committee is to analyze the distribution among specialties of physicians and medical students and to evaluate alternative approaches to ensure an appropriate balance. The Committee will also encourage bodies controlling the number, types, and geographic location of graduate training positions to provide leadership in achieving the recommended balance.

Authority

42 USC 217a; section 222 of the Public Health Service Act, as amended. The Committee is governed by provisions of Public Law 92-463, which sets forth standards for the formation and use of advisory committees.

Functions

The Graduate Medical Education National Advisory Committee shall advise, consult with and make recommendations to the Secretary on overall strategies on the present and future supply and requirements of physicians by specialty and geographic location; translation of physician requirements into a range of types and numbers of graduate training opportunities needed to approach a more desirable distribution of physician services, taking into account National Health Planning goals, guidelines, standards, and, as appropriate, the health system plans developed by health system agencies; factors which affect physician career choice; the impact of various activities which influence specialty distribution and the availability of training opportunities, including systems of reimbursement of services and financing of graduate medical education; and the relationship of graduate medical education to the provision of services in training institutions, including alternatives for the provision of these services.

The Committee shall advise on data requirements and systems needed to conduct the activities of the Committee; propose national goals for the distribution of physicians in graduate training; and recommend Federal policies, strategies, and plans to achieve the established goals in concert with the private sector and non-Federal agencies.

Structure

The Committee shall consist of 21 members, including the Chairperson. Members shall be selected by the Secretary or his designee, and the Chairperson shall also be designated by the Secretary or his designee. Three shall be ex officio members who are representatives of the Public Health Service, Department of Defense and Veterans Administration and the remaining 18 members shall be representatives of health care providers, payers, and interested national and local organizations.

Members shall be invited to serve for overlapping four-year terms; terms of more than two years are contingent upon the renewal of the Committee by appropriate action prior to its termination.

Management and staff services shall be provided by the Bureau of Health Manpower, Health Resources Administration and a Program Officer, who shall serve as Executive Secretary.

Meetings

Meetings shall be held at least quarterly at the call of the Chairperson with advance approval of a Government official who shall also approve the agenda. A Government official shall be present at all meetings.

Meetings shall be open to the public; notice of all meetings shall be given to the public.

Meetings shall be conducted, and records of the proceedings kept, as required by applicable laws and departmental regulations.

Compensation

Members who are not full-time Federal employees shall be paid at the rate of $100 per day, plus per diem and travel expenses in accordance with Standard Government Travel Regulations.

Annual Cost Estimate

Estimated annual cost for operating the Committee, including compensation and travel expenses for members and other consultants, but excluding staff support is $79,000. Estimate of annual man-years of staff support required is 2.5 at an estimated annual cost of $72,800.

Reports

An annual report shall be submitted to the Secretary, through the Assistant Secretary for Health, not later than December 15 of each year, which shall contain as a minimum a list of members and their business addresses, the Committee's functions, dates, and places of meetings, and a summary of the Committee's activities and recommendations made during the fiscal year. Within 18 months of the establishment of the Committee, recommendations will be provided to the Secretary on the Committee's findings to date. A copy of the report shall be provided to the Department Committee Management Officer.

Termination Date

Unless renewed by appropriate action prior to its expiration, the Graduate Medical Education National Advisory Committee will terminate two years from the date this charter is approved.

APPROVED:

APR 20 1976

Date

Secretary

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D.C. 20201

CHARTER

GRADUATE MEDICAL EDUCATION NATIONAL ADVISORY COMMITTEE

Purpose

The Secretary and, by delegation, the Assistant Secretary for Health are charged under Title VII of the Public Health Service Act with responsibility for taking national leadership in the development of programs addressed to graduate medical education and in the research, development, and analysis for programs that impact on the health manpower needs of this Nation. The purpose of this Committee is to analyze the distribution among specialties of physicians and residents and to evaluate alternative approaches to ensure an appropriate balance. The Committee will also encourage bodies controlling the number, types, and geographic location of graduate training positions to provide leadership in achieving the recommended balance.

Authority

42 USC 217a; section 222 of the Public Health Service Act, as amended. The Committee is governed by provisions of Public Law 92-463, which sets forth standards for the formation and use of advisory committees.

Functions

The Graduate Medical Education National Advisory Committee shall advise, consult with and make recommendations to the Secretary on overall strategies on the present and future supply and requirements of physicians by specialty and geographic location; translation of physician requirements into a range of types and numbers of graduate training opportunities needed to approach a more desirable distribution of physician services, taking into account National Health Planning goals, guidelines, standards, and, as appropriate, the health system plans developed by health system agencies; factors which affect physician career choice; the impact of various activities which influence specialty distribution and the availability of training opportunities, including systems of reimbursement of services and financing of graduate medical education; and the relationship of graduate medical education to the provision of services in training institutions, including alternatives for the provision of these services.

The Committee shall advise on data requirements and systems needed to conduct the activities of the Committee; propose national goals for the distribution of physicians in graduate training; and recommend Federal policies, strategies, and plans to achieve the established goals in concert with the private sector and non-Federal agencies.

Structure

The Committee shall consist of 21 members, including the Chairperson. Members shall be selected by the Secretary or his designee, and the Chairperson shall also be designated by the Secretary or his designee. Three shall be ex officio members who are representatives of the Public Health Service, Department of Defense and Veterans Administration and the remaining 18 members shall be representatives of health care providers, payers, and interested national and local organizations.

Members shall be invited to serve for overlapping four-year terms; terms of more than two years are contingent upon the renewal of the Committee by appropriate action prior to its termination.

Management and staff services shall be provided by the Bureau of Health Manpower, Health Resources Administration (HRA). A Program Officer, who shall serve as Executive Secretary, shall be located in the office of the Administrator, HRA, and shall report directly to the Administrator.

Meetings

Meetings shall be held at least quarterly at the call of the Chairperson with advance approval of a Government official who shall also approve the agenda. A Government official shall be present at all meetings.

Meetings shall be open to the public; notice of all meetings shall be given to the public.

Meetings shall be conducted, and records of the proceedings kept, as required by applicable laws and departmental regulations.

Compensation

Members who are not full-time Federal employees shall be paid at the rate of $100 per day, plus per diem and travel expenses in accordance with Standard Government Travel Regulations.

Annual Cost Estimate

Estimated annual cost for operating the Committee, including compensation and travel expenses for members and other consultants, but excluding staff support is $86,030. Estimate of annual man-year of staff support required is 2.5, at an estimated annual cost of $75,800.

Reports

An annual report shall be submitted to the Secretary, through the Assistant Secretary for Health, not later than December 15 of each year, which shall contain as a minimum a list of members and their business addresses, the Committee's functions, dates, and places of meetings, and a summary of the Committee's activities and recommendations made during the fiscal year. A copy of the report shall be provided to the Department Committee Management Officer.

Recommendations on the Committee's findings to date will be provided to the Secretary eight months after the execution of this charter and at the conclusion of the charter period.

Termination Date

Unless renewed by appropriate action prior to its expiration, the Graduate Medical Education National Advisory Committee will terminate April 20, 1980.

APPROVED:

MAY 1 1978
Date

Joseph A. Califano, Jr.
Secretary

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D.C. 20201

CHARTER

GRADUATE MEDICAL EDUCATION NATIONAL ADVISORY COMMITTEE

Purpose

The Secretary and, by delegation, the Assistant Secretary for Health are charged under Title VII of the Public Health Service Act with responsibility for taking national leadership in the development of programs addressed to graduate medical education and in the research, development, and analysis for programs that impact on the health manpower needs of this Nation. The purpose of this Committee is to analyze the distribution among specialties of physicians and residents and to evaluate alternative approaches to ensure an appropriate balance. The Committee will also encourage bodies controlling the number, types, and geographic location of graduate training positions to provide leadership in achieving the recommended balance.

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The Graduate Medical Education National Advisory Committee shall advise, consult with and make recommendations to the Secretary on overall strategies on the present and future supply and requirements of physicians by specialty and geographic location; translation of physician requirements into a range of types and numbers of graduate training opportunities needed to approach a more desirable distribution of physician services, taking into account National Health Planning goals, guidelines, standards, and, as appropriate, the health system plans developed by health system agencies; factors which affect physician career choice; the impact of various activities which influence specialty distribution and the availability of training opportunities, including systems of reimbursement of services and financing of graduate medical education; and the relationship of graduate medical education to the provision of services in training institutions, including alternatives for the provision of these services.

The Committee shall advise on data requirements and systems needed to conduct the activities of the Committee; propose national goals for the distribution of physicians in graduate training; and recommend Federal policies, strategies, and plans to achieve the established goals in concert with the private sector and non-Federal agencies.

Structure

The Committee shall consist of 24 members, including the Chairperson. Members shall be selected by the Secretary and the Chairperson shall also be designated by the Secretary. Three shall be ex officio members who are representatives of the Public Health Service, Department of Defense, and Veterans' Administration and the remaining 21 members shall be representatives of health care providers, payers, and interested national and local organizations.

Members shall be invited to serve for overlapping four-year terms; terms of more than two years are contingent upon the renewal of the Committee by appropriate action prior to its termination.

Management and staff services shall be provided by the Office of Graduate Medical Education, Office of the Administrator, Health Resources Administration (HRA), and the Executive Secretary, Graduate Medical Education National Advisory Committee.

Meetings

Meetings shall be held at least quarterly at the call of the Chairperson with advance approval of a Government official who shall also approve the agenda. A Government official shall be present at all meetings.

Meetings shall be open to the public; notice of all meetings shall be given to the public.

Meetings shall be conducted, and records of the proceedings kept, as required by applicable laws and departmental regulations.

Compensation

Members who are not full-time Federal employees shall be paid at the rate of $100 per day, plus per diem and travel expenses in accordance with Standard Government Travel Regulations.

Cost Estimate

Estimated annual cost for direct operations of the committee member expenses for Fiscal Year '80, but excluding staff support, is $263,700. This cost estimate was predicated on the Committee's termination on April 20, 1980. Funding of the Committee will be held to this estimate, despite extension of the Committee's charter through September 30, 1980. Estimated direct staff support required is 2.5, at an estimated cost of $75,800.

Reports

A report shall be submitted to the Secretary, through the Assistant Secretary for Health, not later than 60 days after termination of the Committee, which shall contain as a minimum a list of members and their business addresses, the Committee's functions, dates, and places of meetings, and a summary of the Committee's activities and recommendations made during the fiscal year. A copy of the report shall be provided to the Department Committee Management Officer.

Recommendations on the Committee's findings will be provided to the Secretary in April 1980, and addendums of these findings at the conclusion of the charter period.

Termination Date

Unless renewed by appropriate action prior to its expiration, the Graduate Medical Education National Advisory Committee will terminate September 30, 1980.

APPROVED:

MAR 6 1980
Date

Patricia Robert Harris
Secretary

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